Dermatology Institute & Skin Care Center
Paul Yamauchi, M.D., PhD | Tsippora Shainhouse MD
Sudi Gooch, PA-C | Ashley Metzger, PA-C | Jennifer Gerace, Esthetician

PATIENT INFORMATION

Name:_____/_____/_____
Last Middle First

Address:_____Apt:_____

City_____State_____Zip_____

Social Security Number:_____ Date of Birth:_____

Cell Number:(_____)_____Home Number:(_____)_____Email:_____

Doctor's Name: _____City_____Number:_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other Are you interested in financing options? ☐ Yes ☐ No

How were you referred to our office?

☐ Doctor ☐ Insurance ☐ Friend ☐ Family Member ☐ Yelp ☐ Google ☐ Facebook ☐ Instagram ☐ Google
☐ Our Website ☐ Other: _____

INSURANCE INFORMATION

Please provide your insurance card

Primary Insurance :_____Secondary)_____

Policyholder:_____Policyholder Date of Birth:_____Relationship to policyholder: _____

EMERGENCY CONTACT

Contact Person: _____Relationship:_____

Home Phone(____)_____Cell Phone(____)_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that **Dermatology Institute & Skin Cancer Center** may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. **Dermatology Institute & Skin Cancer Center** has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask **Dermatology Institute & Skin Cancer Center** will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow **Dermatology Institute & Skin Cancer Center** to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that **Dermatology Institute & Skin Cancer Center** has taken action relying on this consent.

SIGNATURE OF PATIENT:_____Date:_____

If patient is a minor: Signature of parent or guardian_____